

STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS

633 17th Street, Suite 1300, Denver, CO 80203 Fax: (303) 866-5909
1259 Lake Plaza Drive, Suite 210, Colo. Springs, CO 80906 Fax: (719) 576-5978
222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Fax: (970) 248-7341

Claimant,

vs.

Employer, and

Respondent.

▲ COURT USE ONLY ▲

WC NUMBER:

DATE OF INJURY:

RESPONSE TO APPLICATION FOR HEARING

A. Response to Application for Hearing: Filed by or for _____ (Print Name of Party)

In addition to the issues marked on the Application for Hearing, the following issues shall be considered at the hearing:

Compensability

Temporary Total Benefits from

Medical Benefits

_____ to _____

Authorized provider

Reasonably necessary

Temporary Partial Benefits from

Average Weekly Wage

_____ to _____

Petition to Reopen Claim

Permanent Partial Disability Benefits

Disfigurement

Permanent Total Disability Benefits

Death Benefits

Penalties: Describe with specificity the grounds on which a penalty is asserted, including the order, rule or section of the statute allegedly violated, and the dates on which you claim the violation began and ended.

Other issues to be heard at this hearing are (such as maximum medical improvement, termination of benefits, etc):

Witnesses to be called at the hearing or by deposition: List names and addresses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(Attach additional pages if necessary)

D. Signature:

X

Signature

Street Address

Print/Type Name

City, State, Zip Code

Attorney Registration Number

Phone Number

Fax Number (Optional)

Date

E-Mail Address (Optional)

E: Certificate of Mailing

I hereby certify that I mailed or delivered the original of the Response to Application for Hearing:

Office of Administrative Courts
633 17th Street, Suite 1300
Denver, CO 80202

Office of Administrative Courts
1259 Lake Plaza Dr., Suite 210
Colorado Springs, CO 80906

Office of Administrative Courts
222 South 6th Street, Suite 414
Grand Junction, CO 81501

And copies to all parties at the addresses shown below: (A claimant must provide a copy to the employer and the insurer, or their attorney.)

Claimant/Respondent or their Representative: _____

Employer or their Representative: _____

Other: _____

Signature

Date Mailed

REV 05/06